Medicare Prescription Drug, Improvement, and Modernization Act of 2003

INPATIENT HOSPITAL PROVISIONS

Sections 401, 402, 403, 406, 501, 503, 504, 505, and 508

- **Equalizing the Standardized Amount**

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) equalizes the urban and rural "standardized amounts" under Medicare's prospective payment system for inpatient hospital services. Currently, Medicare has two different operating base payments for inpatient hospital services—one for hospitals located in large urban areas and another, smaller payment for hospitals located in rural and small urban areas. This provision establishes a single base payment, or standardized amount, for hospitals in all areas in the 50 states, the District of Columbia, and Puerto Rico, starting in FY 2004.

- **Decreasing the Labor-Share**

Beginning in FY 2005, the MMA revises the labor-related share of the wage index used in Medicare's prospective payment system for inpatient hospital services. It reduces the labor-related share of the wage index to 62 percent (currently it is 71.1 percent), unless such revision would result in lower payments. The labor share is an estimate of the national average proportion of hospitals' costs associated with inputs that are directly or indirectly affected by local wage levels. Many rural hospitals argue that, because their local wage levels are low, they are adversely affected by a high labor-related share.

- **Market Basket Update**

For fiscal years 2005 through 2007, hospitals will receive the full market basket update if they submit the 10 hospital quality measures the Secretary has established as of November 1, 2003. If hospitals do not submit the 10 quality measures, then they will receive an update of market basket minus 0.4 percentage points. Hospitals have a 30-day grace period to submit data with respect to the FY 2005 update.

- **Disproportionate Share Hospital (DSH) Payments**

The MMA modifies Medicare's payments for those hospitals that furnish care to a disproportionate share of low-income and uninsured patients. Currently, the disproportionate share hospital adjustment paid to rural and small urban hospitals is capped at 5.25 percent. The MMA increases the rural and small urban cap to 12 percent.

- **Puerto Rico Hospitals**

In the bipartisan agreement, the PPS rate for hospitals in Puerto Rico will be permanently increased to 75 percent of the national rate in FY 2005. From April 1, 2004 through September 30, 2004, the payment amount for Puerto Rico hospitals is changed to 62.5 percent federal rate and 37.5 percent local Puerto Rico rate. The payment amount changes to 75 percent federal rate and 25 percent local Puerto Rico rate in FY 2005 and subsequent fiscal years.

- **Low Volume Hospitals**.

The MMA establishes an additional payment for low-volume hospitals. Eligible hospitals are those that are located more than 25 miles away from another hospital and have less than 800 discharges in a given year. The Secretary is charged with determining the applicable percentage increase based on the relationship between costs and discharges for low-volume hospitals. The maximum total adjustment may not exceed 25 percent of the otherwise applicable prospective payment rate.

- **New Technology**

The agreement modifies the way Medicare pays for the cost of new medical services and technologies under the inpatient prospective payment system. It adjusts the threshold for which technologies and services qualify to receive the new technology add-on payments, and requires more public input in the process.

- **Wage Index Adjustment for Out-Bound Commuting**

Effective beginning FY 2005, the Secretary must establish a new process to make payment adjustments to certain hospitals based on the commuting patterns of hospital employees. Some of the requirements are: at least 10 percent of residents in a qualifying county are commuting to hospitals in areas that have higher wage index values, and the average hourly wage of the hospital exceeds the average hourly wage of all hospitals in the qualifying area. Hospitals that qualify for the payment adjustment will receive a blended wage index amount based on the percent of employees who commute to adjacent MSAs that have a higher wage index. The wage index increase is effective for 3 years unless a hospitals requests to terminate the payment.

- **One Time Appeal of Reclassification**

The MMA directs the Secretary to establish a process for hospitals to appeal their wage index classification and be reclassified to another area within the State, or to an area in a contiguous State. Currently, hospitals may apply for reassignment to another geographic area for purposes of using the other area's wage index if they meet certain qualifications. This provision allows the Secretary to adjust and create new criteria for a one-time reclassification appeal process. A successful hospital will be reclassified for 3 years beginning April 1, 2004. Expenditures for this section are limited to $900 million.

In addition, the reclassification of the following counties is extended from January 1, 2004 through September 30, 2004:

- Iredell County, North Carolina, is deemed to be located in the Charlotte-Gastonia-Rock Hill, North Carolina-South Carolina Metropolitan Statistical Area;
- Orange County, New York, the large urban area of New York, New York is deemed to include such county;
- Lake County, Indiana, and Lee County, Illinois, are deemed to be located in the Chicago, Illinois Metropolitan Statistical Area;
- Hamilton-Middletown, Ohio, is deemed to be located in the Cincinnati, Ohio-Kentucky-Indiana Metropolitan Statistical Area;
- Brazoria County, Texas, is deemed to be located in the Houston, Texas

Metropolitan Statistical Area; and

- Chittenden County, Vermont, is deemed to be located in the Boston-Worcester-Lawrence-Lowell-Brockton, Massachusetts-New Hampshire Metropolitan Statistical Area.